Virginia School for the Deaf and the Blind
Student Health Center
Phone: 540-332-9027 or 540-332-9026
Fax: 540-332-2244

STUDENT MEDICATION FORM

Student Name: _____Date of Birth: _____

Prescribing Physician:

I certify that the prescribed medications, including over-the-counter medications and supplements, listed below are medically necessary for this student while he/she is attending VSDB. The medications listed below may be administered by school staff. These medication orders will be valid for one year unless otherwise stated; any changes to these prescriptions require new written orders.

Prescribed Medication Name, Dosage, Time, Route, and Reason for Medication:

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____

Telephone: _____ Fax: _____

Parent/Guardian:

I give permission for VSDB nursing staff and medication aids to administer the medications as prescribed above. I also give permission for the school to contact the above health care provider regarding the administration of these medications. I understand that I am responsible for providing these medications in a properly labeled pharmacy container to school staff.

Signature of Parent/Guardian: _____

Date: _____

NOTE: Please return this form to the Student Health Center at VSDB.